EMPLOYEE HEALTH SERVICES



NON-COUNTY HEALTH CLEARANCE INSTRUCTIONS

Welcome to Los Angeles County, Department of Health Services. You are required to obtain a health clearance by Employee Health Services (EHS) prior to beginning your work assignment. You must successfully complete the Human Resources in-processing and criminal background check prior to beginning the EHS health clearance process. This packet includes health screening forms and questionnaires that should be completed by you and your physician or a licensed health care professional prior to your visit to EHS for your health clearance. Only return the E2 certificate to EHS on the day of your appointment/visit. Completed forms and questionnaires should be returned to your school/contract agency and kept in your personnel file.

This packet contains the following forms/questionnaires:

- ✓ <u>E2</u> This form is a certificate of health clearance certified by your physician or licensed health care professional (PLHCP) and school/contract agency that you have met DHS health screening requirements. This form is to be completed by your PLHCP (Section I), you (Section II) and your school/contract agency (Section III). Return this certificate only, unless specifically noted to submit form(s) to EHS.
- ✓ <u>B-NC</u> This form contains Tuberculosis (TB) questionnaire and is used as a template to provide evidence of immunity to vaccine-preventable diseases. If you have documentation of a 2-step TB test record or chest x-ray (within the past 12 months) and immunization record, please bring them with you for review by your PLHCP. Your records may be acceptable to meet DHS health clearance requirement.
- ✓ <u>K-NC</u> This form is a declination to receiving vaccines. If you decline to receive the recommended vaccine(s) as listed on form B-NC, you must provide a reason for the declination on this form. This form must be signed by you and your school/contract agency, and submitted with the E2 certificate to EHS.
- ✓ <u>N-NC</u> This form is used for a N95 respirator fit test to be completed by your PLHCP. If your job assignment requires a N95 respirator, you must be fit tested for the N95 respirator. If your job assignment involves Airborne Infection Isolation Rooms (AIIR), you will need to be fit tested. If your job assignment does not involve AIIR, you will not need to complete this form or the questionnaire below (Form P-NC).
 - <u>P-NC</u> This form is an Aerosol Transmissible Disease Respirator Medical Evaluation Questionnaire. You must complete this questionnaire and submit to your PLHCP prior to the respirator fit test.
 - **NOTE**: N95 respirator is the most commonly used respirator in DHS facility, however, if you need a respirator greater than a N95 (such as full-face respirator), you must complete the Respirator Medical Evaluation Questionnaire (Form O-NC) and submit to your PLHCP prior to fit test. Form O-NC is available on EHS link at www.dhs.lacounty.gov.

Once you have been cleared by EHS, you may report to Human Resources to obtain an ID badge and begin your work assignment. If you have any questions, please contact the facility EHS.

Sincerely,

EMPLOYEE HEALTH SERVICES

E2

EMPLOYEE HEALTH SERVICES

HEALTH CLEARANCE CERTIFICATION

Health Services could be served to see the services of the services could be served to serve the services of t			FOR NON-DHS/NON-COUNTY WFM						
LAST NAME	FIRST, MIDDLE NAME			BIRTHDATE		DER	HSN NO.		
JOB TITLE		DHS FACILITY		ONSITE DEPT/DIVISION		ONSITE WORK AREA/UNIT		RK AREA/UNIT	
ONSITE WORK PHONE	OORDINATOR NAME YOU		YOUR E-MAIL ADDRESS		YOUR CELL/PAGER NO.				
NAME OF SCHOOL/CONTRAC	ΓOR	PI	HONE NO.		CONT	ACT PERSON			
Completion of this cert	ificate ce	rtifies the individual in	dentifi	ied above	has met the	los An	عوامه	County Department of	•

Completion of this certificate certifies the individual identified above has met the Los Angeles County Department of Health Services (DHS) Pre-placement Health Screening Section A, OR Annual Health Screening Section B, requirements in accordance with DHS policy.

I. FOR COMPLETION BY THE PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL (PLHCP)

INSTRUCTIONS TO THE PLHCP: Please complete the following forms. All fields on the forms must be completed in order to meet DHS health clearance requirements to work in DHS health care facilities. Return completed forms to the patient. **Only complete** <u>one</u> section (Section A <u>or</u> B).

Section A	FOR PRE-PLACEMEN (Must complete form B-NC.	T HEALTH SCREENING (ONE TIME Complete forms K-NC, N-NC and P-NC, as	use <u>for initial pre-p</u> s <mark>applicable</mark>)	lacement only):						
☐ B-NC	Tuberculosis History and E	Evidence of Immunity Form								
☐ K-NC	Declination Form, if workforce member (WFM) declined any vaccination(s). (If applicable, complete and submit form K-NC to DHS-EHS)									
☐ N-NC		pirator is needed for job assignment (WFI o may be assigned work in airborne preca								
	WFM must complete the years thereafter or more	following medical questionnaire form frequently, as needed)	P-NC <u>prior to</u> Fit Tes	st, then <u>every 4</u>						
	* NOTE : If WFM requi	ATD Respirator Medical Evaluation Ques res a respirator greater than N95 respirator sestionnaire (Form O-NC) from EHS webs	or, please obtain and	complete the						
Section B	FOR ANNUAL HEALTH (Must complete form E-NC.	H SCREENING (Use <u>annually</u>): Complete forms K-NC, N-NC and P-NC, as	s applicable)							
☐ E-NC	Annual Health Screening INOTE: For new TB Conv	Form version, attach form E-NC and submit to	DHS-EHS.							
☐ K-NC	Declination Form, if WFM	declined any vaccination(s). (If applicab	le, submit form K-N	C to DHS-EHS)						
☐ N-NC		irator is needed for job assignment <mark>(WFM</mark>		clinicians,						
		o work in airborne precaution areas or pro	,							
	WFM must complete the years thereafter or more	following medical questionnaire form frequently, as needed)	P-NC <u>prior to</u> Fit Tes	st, then <u>every 4</u>						
	* NOTE : If WFM requi	TD Respirator Medical Evaluation Questic res a respirator <u>greater</u> than N95 respirato Juestionnaire (Form O-NC) from EHS webs	or, please obtain and	complete the						
Department	I certify that the individual identified above has met the Los Angeles County Department of Health Services Pre-placement OR Annual health screening requirements AND verified completion of the forms.									
PRINT NAME		PLHCP SIGNATURE	LICENSE NO.	TODAY'S DATE						
FACILITY NAME/ADDRESS PHONE NO.										

E2

NON-DHS/NON-COUNTY WORKFORCE MEMBER HEALTH CLEARANCE CERTIFICATION

Page 2	2 of 2
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LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

FOR COMPLETION BY THE WORKFORCE MEMBER

INSTRUCTION TO THE WORKFORCE MEMBER: You must provide authorization to release your health information to your School/Contract Agency/Independent Contractor (SCAIC) and to DHS-EHS by signing below. Return all completed forms to your SCAIC for verification of completion and to store source documents.

I authorize the release of my health information as listed in Section A or B to my SCAIC and to DHS-EHS, and upon request by DHS-EHS for regulatory requirements and auditing purposes. The purpose of releasing my health information is to meet DHS pre-placement or annual health screening requirements. DHS forms shall be maintained and filed at my SCAIC and at DHS-EHS as applicable. I understand that my SCAIC and DHS-EHS may not use or disclose my health information unless another authorization is obtained from me or unless such use or disclosure is specially required or permitted by law. By signing this, I am authorizing the release of my health information.

PRINT NAME	SIGNATURE	DATE

Ш. FOR COMPLETION BY THE SCHOOL/CONTRACT AGENCY/INDEPENDENT **CONTRACTOR (SCAIC)**

INSTRUCTION TO THE HOME SCHOOL/CONTRACT AGENCY/INDEPENDENT CONTRACTOR: You must verify all forms are accurately completed and ensure the workforce member (WFM) has met the DHS health clearance requirements. Sign below and return this E2 certificate only (original to be kept by SCAIC) unless specifically noted to submit form(s) in Section A or B to DHS-EHS.

E2 certificate ONLY must be presented to DHS-EHS for final health clearance.

In accordance with DHS policy, the WFM's SCAIC shall:

- 1. Maintain and file original E2, B-NC or E-NC and other forms as applicable at the WFM's Home SCAIC, and must ensure the confidentiality and privacy of WFM's health information.
- 2. Ensure the above WFM completes a health screening annually by the end of the month of last health screening. Failure to provide documentation of timely health screening/clearance will result in immediate termination of assignment and placement in a "Do Not Send" status until compliant.
- 3. Provide health surveillance/post-exposure services to WFM. If the WFM's SCAIC chooses to have DHS-EHS perform such surveillance/post-exposure services, the WFM's SCAIC will be billed, as appropriate.

As the WFM's SCAIC, I certify that I have verified DHS forms are complete to ensure the health clearance requirements are complete and, upon DHS request, will supply supporting document(s) within four (4) hours. WFM will comply with DHS policy and will complete health screening annually.

PRINT NAME	SIGNATURE	DATE	
E-MAIL ADDRESS	NAME OF SCHOOL/CONTRACT AGENCY/SELF	PHONE NO.	
SCHOOL/CONTRACT AGENCY/SELF ADDRESS		STATE	ZIP CODE

SAVE ORIGINAL FOR YOUR RECORDS SUBMIT COPY OF E2 FORM INCLUDING K-NC or E-NC. AS NECESSARY

	DHS-EHS STAFF ONLY	
DATE CLEARED BY EHS	PRINT NAME	SIGNATURE

DHS-EHS is to provide Form A2 or E3 to WFM for Area/Unit File



TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

GENERAL INSTRUCTIONS on la	FOR NON-DHS/NON-COUNTY WFM								
LAST NAME FIRST, MIDDLE NAME				BIRTHDATE HSN NO.).		
JOB TITLE	DHS FACILITY DEPT/			DIVISION		WORK AREA/UNI		IT	SHIFT
E-MAIL ADDRESS	WORK PHONE		CELL/PAGER NO)	SUPER	VISOR NA	AME	
NAME OF SCHOOL/EMPLOYER (If applicable	e)			PHONE NO.			CONTA	CT PERS	ON

FOR COMPLETION BY WORKFORCE MEMBER (WFM)

TUBERCULOSIS QUESTIONNAIRE

			_		NO QUEUTIONNAINE								
VFS	NO ³		ın										
ILS	JUIN	_ !	10	TUBI	ERCULOSIS (TB) HISTORY								
		П	7		` '								
				Do you have documentation of your negative test from the last 12 months?									
				3.	Do you have a history of a positive TB skin test?								
				4.	Do you have documentation of your positive skin test in millimeters?								
				5.	Do you have documentation of a chest X-ray within the last year?								
				6.	Have you received treatment for TB (INH)?								
					If "yes", how many months?								
				7.	Do you have treatment documentation?								
				8.	Have you ever been diagnosed as having active or infectious TB?								
				9.	Have you received a TB vaccine called BCG?								
				10.	Have you had a weakened immune system due to (check all that applie	s):							
					☐ Chemotherapy ☐ HIV ☐ Organ transplant								
					☐ Cancer or medications ☐ Hodgkin's Disease ☐ Steroids (e.g., pr								
					 Having immunodeficiency increases a person's risk for active TB infection be immunocompromised you should consult with your physician or licen 								
					EHS does not test for HIV or related diseases.	sed fleatiff care professional.							
					ERCULOSIS (TB) SCREENING								
		1 [T	11.	Do you have a cough lasting longer than three (3) weeks?								
				12.	Do you cough up blood?								
				13.	Do you have unexplained or unintended weight loss?								
				14.	Do you have night sweats (not related to menopause)?								
				15.	Do you have a fever or chills?								
				16.	Do you have excessive sputum?								
	7 7 17. Do you have excessive fatigue?												
				18.	Have you had recent close contact with a person with TB?								
WC	DRKI	OR	CE	MEMBI	ER SIGNATURE	DATE							

B-NC

CONFIDENTIAL TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY PAGE 2 OF 4

LAST NAME	FIRST NAME	BIRTHDATE	HSN NO.

FOR COMPLETION BY EMPLOYEE HEALTH STAFF - OR - DESIGNATED WFM AGENCY

TUBERCULOSIS DOCUMENTATION HISTORY													
		0.4			TUBERCUI								STATUS
		0.1 m	ii ot 5 tube	ercuiin un	iits (10) pur	rified protein derivative (PPD) a			1				Indicate: Reactor
	DATED PLACED	STEP	MANUFA	CTURER	LOT#	EXP SITE *ADM BY (INITIALS)		DATE *READ BY RE		RES	ULT	Non-Reactor Converter	
Α		1st											
		2nd											
		lf ei	ther res	ult is p	ositive, s	send fo	or CXR a	nd com	plete S	ection C	belo	ow.	
	If either result is positive, send for CXR and complete Section C below. OR												
В	Negative			Date:		Results				County side Docum		STAT	us
	,	-	CVD io	nocitiv	o for TD	DO N		ND for b					
		"			re for TB _: force Me								
	Ī								ПІАС	County		STAT	US
С	Positive	TST		Date:		Resultsmm			Outside Document				
	CXR (<1	2 months	s)	Date:		Results_			LA County Outside Document				
						OR							
	_			r		O	R		1				
D	Positive	BAMT		Date:		Results			LA County Outside Document			STAT	US
	CXR (<1	2 months	s)	Date:		Results_			LA County Outside Document				
						0	R						
	History of Treatment		ΓB with	Date:		m	nonths with		Outs	side Docum	ent	STAT	US
E	CXR (<12 months)			Date:		Results_			☐ Outside Document				
	_					0	R						
	History of LTBI Treatment			Date:		months with			Outside Document			STAT	US
F	CXR (<1	2 months	s)	Date:		Results_			☐ Outside Document		ent		

B-NC

LAST NAME

CONFIDENTIAL TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY PAGE 3 OF 4

HSN NO.

BIRTHDATE

	IMMUNIZA	TION DOC	JMENTATION HIS	TORY	(THESE VAC	CINATION	S ARE MAN	IDATOR	Y)			
		Date Received	Titer	Vac	immune, give cination x 2, ss Rubella x 1	Date Received	Vaccine		v	Declined accination		
	Measles		Immune Non-Immune Equivocal Laboratory confirm of disease	OR	X 2			OR	WFM Form specif	M declines, must complete K-NC <u>AND</u> iy reason(s) for lation.		
G	Mumps		Immune Non-Immune Equivocal Laboratory confirm of disease	OR	X 2			OR	WFM Form specif	M declines, must complete K-NC <u>AND</u> iy reason(s) for lation.		
	Rubella		Immune Non-Immune Equivocal Laboratory confirm of disease	OR	X 1			OR	WFM Form specif	M declines, must complete K-NC <u>AND</u> iy reason(s) for lation.		
	Varicella		Immune Non-Immune Equivocal Laboratory confirm of disease	OR	X 2			OR Specific		M declines, must complete K-NC <u>AND</u> fy reason(s) for lation.		
			_		AND			-		_		
	Vaccination	1		Date Received			Declined Vaccine					
Н	Tetanus-dip Every 10 ye	htheria (Td) ars					☐ Verbal ☐ Document					
	Arcellular Pe	ertussis (Tdap) X 1			☐ Verbal ☐ Docun						
	-				AND					_		
ı			RY for WFM who hat to blood or body flood		Date Received	Immunity	1			Declined Vaccine		
•	Hepatitis B (HBsAb)					☐ Reacti	☐ Reactive ☐ Non reactive ☐ N/A					
_					AND							
	Vaccination	ı (VOLUNTAI	RY) Date Receive	d	Location Rece	eived				Declined Vaccine		
J	Seasonal In (Annually)	fluenza						Verbal Docume	nt			
	_											

FIRST, MIDDLE NAME



ATTACH SUPPORTING DOCUMENTATION(S) WITH THIS FORM INCLUDING FORM K-NC IF WFM DECLINED VACCINATION(S)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635



CONFIDENTIAL TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY PAGE 4 OF 4

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

GENERAL INSTRUCTIONS FOR EACH SECTION

SECTION	AL INSTRUCTIONS FOR EACH SECTION
	TUBERCULOSIS DOCUMENTATION HISTORY
	ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT
A	WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually. a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work; b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work. If TST is positive, record results and continue to Section C.
В	WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (BAMT). If negative result, WFM is cleared to work. WFM shall receive either TST or BAMT and symptom screening annually. a. Documentation of negative BAMT within 12 months will be accepted. WFM is cleared to work. If BAMT is positive, record results and continue to Section D.
	TST POSITIVE RESULTS
	If CHEST X-RAY IS POSITIVE, <u>DO NOT CLEAR</u> FOR HIRE/ASSIGNMENT, AND REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE
С	If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
D	If BAMT is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. WFM shall be symptom screened for TB annually.
E	If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
F	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR within 12 months prior to placement will be accepted for clearance to work. If documentation is supported, WFM is cleared to work. WFM shall be symptom screened for TB annually. Record documentation result in this section.
	IMMUNIZATION DOCUMENTATION HISTORY
WFM shall be who declines	on of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date vaccination, DHS or WFM contract agency will make the vaccination available.
G	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted OR documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine vary depending on state or local requirements. Varicella doses shall be at least 4 week between doses for WFM. If Equivocal, WFM needs either vaccination or redraw with positive titer. DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.
Н	<u>Td</u> – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose. <u>Tdap</u> should replace a one time dose of Td for HCP aged 19 though 64 years who have not received a dose of Tdap previously. An interval as short as 2 years or less from the last dose of Td is recommended for the Tdap dose.
I	All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B surface antigen HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.
J	Seasonal influenza is offered annually to WFM when the vaccine becomes available.

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.



EMPLOYEE HEALTH SERVICES

DECLINATION FORM

LOS ANGELES COUNTY					R NOI	N-DHS	S/NON	-COU	NTY WFM
LAST NAME	FIRST,	MIDDLE NAME			BIRTHE	OATE		HSN N	O.
JOB CLASSIFICATION	DHS F	ACILITY	DEPT/D	DIVISION		WORK	AREA/UN	NIT	SHIFT
E-MAIL ADDRESS		WORK PHONE	ı	CELL/P	AGER NO)	SUPER	VISOR N	NAME
NAME OF SCHOOL/EMPLOYER (If applicable)	I		PHONE	NO.		CONTA	CT PER	SON
Please check in the section(s) as apply AND indicate reason for the declination. Submit original to DHS-EHS.									
I. 3 CCR §5199. Appendix	x C1 -	Vaccinatio	n Dec	linatio	n Stat	temen	t (Mar	ndato	ry)*
Please check as apply: Measle	es [Mumps	Ru	bella	□v	aricella		Td/Tda	р
I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection as indicated above. I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring the above infection, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination from my School/Employer or DHS-Employee Health Services (EHS) at no charge to me. Reason for declination:									
☐ I am allergic to vaccine cor☐ I believe I can get the flu if☐ I am concerned about vacc	Seasonal Influenza Reason for declination (check as apply): I am allergic to vaccine components. I believe I can get the flu if I get the shot. I am concerned about vaccine side effects. It's against my personal belief.								
II. 8 CCR §5193. Append	ix A-H	lepatitis B	Vaccir	e Dec	linatio	on (Ma	ndato	ry)*	
Hepatitis B I understand that due to my occupational exposure to blood or other potentially infectious material (OPIM) I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to me. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or OPIM and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series from my School/Employer or DHS-EHS at no charge to me. Reason for declination:									
III. Specialty Surveillance	Decl	ination (Ma	ndato	ry) <u>*</u> *					
Please check as apply: Ashes	tos [Hazardous	/Anti-Ne	onlastic	Druge		Other:		



DECLINATION FORM PAGE 2 OF 2

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

I understand that due to my occupational exposure as indicated above, I am eligible and have been given the opportunity to enroll in the Medical Surveillance Program. This will enable me to receive specific initial, periodic and exit medical examinations for the hazard identified above, at no charge to me and at a reasonable time and place.

However, I decline to be enrolled in this program at this time. I understand that by declining this enrollment, I will not be medically monitored for occupational exposure to this hazard. I understand that it is strongly recommended that I complete a medical questionnaire or examination. I also understand that if in the future I continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.

continue to have occupational exposure to the hazard identified above and I want to be enrolled in the Medical Surveillance Program, I can do so at any time at no charge to me.					
Reason for declination:					
SIGN BELOW					
By signing this, I am declining as indic	cated on this form.				
WORKFORCE MEMBER SIGNATURE		DATE			
SCHOOL/EMPLOYER (PRINT NAME)	SIGNATURE	DATE			

MAKE A COPY FOR YOUR RECORDS SUBMIT ORIGINAL AND ANY SUPPORTING DOCUMENT(S)

*Vaccination(s) is available to all workforce members (WFM), and free of charge for County employees and volunteers. Non-County WFM should obtain the vaccinations from their physician or licensed health care professional. Services provided through DHS will be billed to the non-County WFM School/Employer, as appropriate.

**Non-County WFM who has potential exposure to occupational hazards will be included in the surveillance program, but will not have their assessments done through the County, unless specified in contract/agreement. Medical surveillance/post-exposure regulations are the responsibility of the school/contract agency. If the non-County WFM School/Employer chooses to have DHS-Employee Health Services (EHS) to perform such surveillance/post-exposure services, the non-County WFM School/Employer will be billed accordingly. Emergency services will be provided post-exposure within the allowable time frames, but will be billed to the contractor/agency, as appropriate.

Workforce member must complete this form if declining DHS recommended and mandatory vaccinations or medical surveillance program. The School/Employer must verify completeness and ensure declination form is submitted to DHS-EHS. The School/Employer must notify DHS-EHS if workforce member does not provide evidence of immunity.

This form and its attachment(s), if any, such as health records shall be maintained and kept in workforce member's EHS health file.



EMPLOYEE HEALTH SERVICES

FOR NON-DHS/NON-COUNTY WFM

RESPIRATORY FIT TEST RECORD

GENERAL INFORMATION OIL IAST	page						
LAST NAME	FIRST, MIDDLE NA	AME		BIRTHDATE		HSN NO.	
JOB TITLE	DHS FACILITY	DEPT/D	DIVISION	WOR	K AREA/UN	IT :	SHIFT
E-MAIL ADDRESS	WORK PI	HONE	CELL/PA	AGER NO	SUPER	VISOR NAM	1E
NAME OF SCHOOL/EMPLOYER (If applicable)	ole)		PHONE	NO.	CONTA	CT PERSOI	V
					ļ.		
RESPI	RATOR, QUEST	IONNAIRE, M	EDICAL	EVALUATIO	N		
EQUIPMENT TYPE:	MANUFACTURER:		МО	DEL: PF	R95-174	SIZE:	☐ Small
N95		ly-Clark			R95-170		☐ Regular
Based on review of the respirator health individual is: Medically approved for only the form 1. Disposable Particulate Record 2. Replaceable Disposable Form 3. Powered Air Purifying Research	ollowing types of resespirators Particulate Respirat	spirator subject	to satisfa	ctory fit test:	3 CCR §51 Full-Facep	`	P-NC), this
4. Self-Contained Breathing			, , ,				
Recommended time period for next ques	stionnaire: 4	ears	er	w	ith justifica	tion	
Date Completed:		Next Due Da	ate:				
List any facial fit problem conditions that	apply to you (e.g.,	beard growth, s	ideburns,	scars, deep w	rinkles): _		
TASTE THRESHOLD SO	REENING (NO f	ood, drink, sn	noke, gι	ım X 15 minu	ıtes befoi	re testing	Ŋ
(Bitrex or Saccha	arin): X 10	☐ X 2	20	X 30	Fa	ail	
,	arin): X 10				☐ Fa	ail	
,	,		CHECK				EMPT #3
,	,	RESSURE FIT	CHECK	K, COMFORT	PT #2	ATTE	EMPT #3
RESI	,	RESSURE FIT	CHECK	ATTEMF	PT #2	ATTE	ss 🗌 Fail
Fit Check: POSITIVE and/or	,	RESSURE FIT ATTEMP Pass	CHECK T #1	ATTEMF	PT #2	ATTE	ss
Fit Check: POSITIVE and/or NEGATIVE pressure	,	RESSURE FIT ATTEMP Pass Pass	CHECK T #1 Fail Fail Fail Fail	ATTEMP Pass Pass	PT #2 Fail Fail Fail	ATTE Pas	ss
Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level	,	RESSURE FIT ATTEMP Pass Pass Pass	CHECK T #1 Fail Fail Fail Fail	ATTEMF Pass Pass Pass	PT #2 Fail Fail Fail	ATTE Pas Pas	ss
Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level	,	RESSURE FIT ATTEMP Pass Pass Pass Pass	CHECK T #1 Fail Fail Fail NA	ATTEMF Pass Pass Pass	PT #2 Fail Fail Fail NA	ATTE	ss
Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level	PIRATOR FIT, PR	Pass Pass Pass FIT TEST	CHECK T #1 Fail Fail Fail NA	C, COMFORT ATTEMF Pass Pass Pass Pass Pass	PT #2 Fail Fail Fail NA	ATTE	Fail Fail Fail NA
Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level Ability to Wear Eyeglasses	PIRATOR FIT, PP	RESSURE FIT ATTEMP Pass Pass Pass Pass Fair FIT TEST ATTEMP	T#1 Fail Fail Fail NA	C, COMFORT ATTEMF Pass Pass Pass Pass ATTEMF	PT #2 Fail Fail Fail NA	ATTE Pas Pas Pas Pas ATTE	Fail Fail Fail NA FAIL NA FAIL NA FAIL NA
Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level Ability to Wear Eyeglasses Normal Breathing (performed for one recognition)	PIRATOR FIT, PR	Pass Pass FIT TEST ATTEMPT Pass Pass Pass Pass Pass Pass Pass Pass	T#1 Fail Fail Fail NA T#1 Fail	Pass Pass	PT #2 Fail Fail NA PT #2 Fail	ATTE Pas Pas Pas ATTE	Fail Fail Fail NA Fail NA FAIL
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Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level Ability to Wear Eyeglasses Normal Breathing (performed for one minimal dependence) Deep Breathing (performed for one minimal dependence) Turning Head Side to Side (performed dependence) Moving Head Up and Down (performed dependence)	ninute) nute) for one minute) d for one minute) d for one minute)	Pass FIT TEST ATTEMP Pass Pass Pass Pass Pass Pass Pass Pa	T#1 Fail Fail Fail Fail Fail Fail Fail Fail	ATTEMF Pass Pass Pass Pass Pass Pass Pass Pa	PT #2 Fail Fail Fail NA Fail Fail Fail Fail Fail	ATTE Pas Pas Pass ATTE Pass Pass ATTE Pas Pas	Fail Fail Fail Fail Fail Fail Fail Fail
Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level Ability to Wear Eyeglasses Normal Breathing (performed for one minimal description of the minimal description o	minute) nute) for one minute) d for one minute) d for one minute)	RESSURE FIT ATTEMP Pass Pass Pass Pass Fail FIT TEST ATTEMP Pass Pass Pass Pass Pass Pass Pass P	T#1 Fail Fail Fail Fail Fail Fail Fail Fail	ATTEMF Pass Pass Pass Pass Pass Pass Pass Pa	PT #2 Fail Fail Fail Fail Tail Fail Fail Fail Fail Fail Fail	ATTE Pas Pas Pass Pass Pass Pass Pas Pas Pas Pas	Fail Fail Fail Fail Fail Fail Fail Fail
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Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level Ability to Wear Eyeglasses Normal Breathing (performed for one minute of the company	minute) nute) for one minute) d for one minute) d for one minute)	Pass Pass	T#1 Fail Fail Fail Fail Fail Fail Fail Fail	ATTEMF Pass Pass Pass Pass Pass Pass Pass Pa	PT #2 Fail Fail Fail NA Fail Fail Fail Fail Fail Fail Fail Fail	ATTE Pas Pas Pass Pass Pass Pas Pas	Fail Fail Fail Fail Fail Fail Fail Fail
Fit Check: POSITIVE and/or NEGATIVE pressure Overall Comfort Level Ability to Wear Eyeglasses Normal Breathing (performed for one minute of the company	minute) nute) for one minute) d for one minute) d for one minute)	Pass Pass	T#1 Fail Fail Fail Fail Fail Fail Fail Fail	ATTEMF Pass Pass Pass Pass Pass Pass Pass Pa	PT #2 Fail Fail Fail NA Fail Fail Fail Fail Fail Fail Fail Fail	ATTE Pas Pas Pass Pass Pass Pas Pas	Fail Fail Fail Fail Fail Fail Fail Fail

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RESPIRATORY FIT TEST RECORD Page 2 of 2

Date

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE		HSN NO.				
 Workforce member failed fit testing. A powered air-purifying respirator (PAPR) must be provided to workforce member. □ WFM trained on PAPR use. □ N/A 								
☐ PASS Pre-Placement FIT Test on: ☐ PASS Annual FIT Test on:								
	ACKNOWLEDGMENT	OF TE	ST RESULTS					
I have undergone fit testing on the al respirator.	I have undergone fit testing on the above respirator. I have been instructed in and understand the proper fitting, use and care of the respirator.							
Workforce Member Signature:	Workforce Member Signature:Date:							
FIT Test Trainer (Print Name):Signature:Date:								
DHS-EHS OFFICE STAFF ONLY								

1	GEI	NER	ΑL	INF	ORI	ЛΑТ	ION
	OL:	451	\sim	1141	OI VI	"	101

Completion of this form:

Pursuant to Title 8 of the California Code of Regulations, Sections 5144 and 5199 (8 CCR §5144 and §5199), all workforce member (WFM) who are required to use respiratory protection must be fit tested with the same make, model, style, and size of respirator to be used. Fit testing procedures for respirators must be conducted for the following:

- Initial fit test must be conducted after the WFM has passed medical evaluation and clearance.
- Newly hired/assigned workforce members who have passed medical evaluation and clearance.
- When new style of respirator face piece is to be worn by WFM.
- Annual fit test for all WFM required to wear a respirator.

Reviewed By (Print)

WFM reports, or the Physician or Licensed Health Care Professional (PLHCP), supervisor, or Program Administrator
makes visual observations of changes in the workforce member's physical condition that could affect respirator fit. Such
conditions include, but are not limited to, facial scarring, facial hair, dental changes, cosmetic surgery, or an obvious
change in body weight.

Signature

- WFM must be given a reasonable opportunity to select a different respirator face piece and be re-fit tested, if required.
- If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM medical information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 CFR Part 1635

P-NC Health Services

EMPLOYEE HEALTH SERVICES

CONFIDENTIAL

NON-DHS/NON-COUNTY WORKFORCE MEMBER 8 CCR SECTION 5199 – APPENDIX B ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

GENERAL INFORMATION on last page

Questionnaire for N95 Respirator

TODAY'S DATE:

BIRTHDATE GENDER

COMPLETE ONCE EVERY FOUR (4) YEARS OR AS NEEDED

This Appendix is Mandatory if the Employer chooses to use a Respirator Medical Evaluation Questionnaire other than the Questionnaire in Section 5144 Appendix C (Form O-NC).

To the PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL: Answers to questions in Section 1, and to question 6 in Section 2 do not require a medical examination. Workforce member must be provided with a confidential means of contacting the health care professional who will review this questionnaire.

To the WORKFORCE MEMBER: Can you read and understand this questionnaire (check one): Yes No

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Please complete this questionnaire in PEN and present to the staff at the examination clinic. **To protect your confidentiality, it should not be given or shown to anyone else.** On the day of your appointment, you must bring a valid driver's license or other form of identification which has both your photograph and signature.

SECTION 1

LAST NAME

PLEASE PRINT LEGIBLY

The following information must be provided by every workforce member who has been selected to use any type of respirator.

FIRST, MIDDLE NAME

HEIGHT	WEIGHT	JC	B TITLE			HSN NO.		
FT IN	I	LBS						
PHONE NUMBER	Ē	Best Tim	e to reach you?			how to contact the health eview this questionnaire?		
Check type of respirator you will use (you can check more than one category): N, R, Or P disposal respirator (filter-mask, non-cartridge type only) Other type (specify):								
Have you worn a respirator?			If "yes", what ty	ype:				

SECTION 2

Questions 1 through 6 below must be answered by every workforce member who has been selected to use any type of respirator (please check "YES", "NOT SURE" or "NO").

YES	NOT SURE	NO	
			Have you ever had the following conditions?
			Allergic reactions that interfere with your breathing?

P-NC	
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ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE Page 2 of 4

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.
NOT			
YES SURE NO			
If "yes," what o	lid you react to?		
	- (f f -		
<u> </u>	a (fear of closed-in places)		
	have any of the following s		
	reath when walking fast on lev		ght hill or incline
	or breath when walking at you		
	reath that interferes with your	***************************************	
	produces phlegm (thick sputu	m)	
	lood in the last month		
	interferes with your job		
	en you breath deeply		
h. Any other sym	ptoms that you think may be r	elated to lung problems:	
3. Do you currently	have any of the following o	ardiovascular or heart sym	nptoms?
a. Frequent pain	or tightness in your chest		
b. Pain or tightne	ss in your chest during physic	al activity	
	ss in your chest that interferes		
d. Any other sym	ptoms that you think may be r	elated to heart problems:	
4. Do you currently	take medication for any of	the following problems?	
a. Breathing or Iu	ng problems		
b. Heart trouble			
c. Nose, throat o	r sinuses		
d. Are your probl	ems under control with these r	medications?	

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635

d. Any other problem that interferes with your use of a respirator

5. If you've used a respirator, have you ever had any of the following problems while respirator is being used? (If you've never used a respirator, check the following space and go to question 6).

6. Would you like to talk to the health care professional about your answers in this questionnaire?

Date

a. Skin allergies or rashes

c. General weakness or fatigue

b. Anxiety

Workforce Member Signature

ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE Page 3 of 4

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

FOR COMPLETION BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL PROVIDE A COPY OF THIS PAGE TO THE WORKFORCE MEMBER

Part 1: Fit Testing Recommendation – Based on Questionnaire				
 ☐ Questionnaire above reviewed. ☐ Medical Approval to Receive Fit Test 1. ☐ Disposable Particulate Respirators 2. ☐ Replaceable Disposable Particulate 3. ☐ Powered Air-Purifying Respirators 4. ☐ Self-Contained Breathing Apparatu 	e Respirator	<u></u> □ t	o. Full Facepie	ece
Recommended time period for next questionnaire: Date Completed: Any recommended limitations for respirator use on	Next Due Date:	_		
The above workforce member has not been closed Additional medical evaluation is needed below. Medically unable to use a respirator.	•	Profess	sional to comp	lete Part 2
☐ Informed workforce member of the results of the	his examination.			
Comments:				_
Part 2: Additional Mo	edical Evaluations	PLICAB	LE	
Medical evaluation completed.Medical Approval to Receive Fit Test				
 Disposable Particulate Respirators Replaceable Disposable Particulate Powered Air-Purifying Respirators Self-Contained Breathing Apparatu 	e Respirator	<u></u> b	o. Full Facepie	ece
 Replaceable Disposable Particulate Powered Air-Purifying Respirators 	e Respirator		·	ece
 Replaceable Disposable Particulate Powered Air-Purifying Respirators Self-Contained Breathing Apparatu Recommended time period for next questionnaire: 	e Respirator	_ with ju	·	ece
 Replaceable Disposable Particulate Powered Air-Purifying Respirators Self-Contained Breathing Apparate Recommended time period for next questionnaire: Date Completed: 	e Respirator	_ with ju	·	ece
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Replaceable Disposable Particulate Replaceable Disposable Particulate Respirators Self-Contained Breathing Apparate Recommended time period for next questionnaire: Date Completed: Any recommended limitations for respirator use on	e Respirator	_ with ju	·	ece
Replaceable Disposable Particulate Powered Air-Purifying Respirators Self-Contained Breathing Apparatu Recommended time period for next questionnaire: Date Completed: Any recommended limitations for respirator use on Medically unable to use a respirator.	e Respirator	_ with ju	·	ece
Replaceable Disposable Particulate Powered Air-Purifying Respirators Self-Contained Breathing Apparatu Recommended time period for next questionnaire: Date Completed: Any recommended limitations for respirator use on Medically unable to use a respirator. Informed workforce member of the results of the	e Respirator	_ with ju	·	ece
2. Replaceable Disposable Particulate 3. Powered Air-Purifying Respirators 4. Self-Contained Breathing Apparatu Recommended time period for next questionnaire: Date Completed: Any recommended limitations for respirator use on Medically unable to use a respirator. Informed workforce member of the results of the Comments: Comments:	e Respirator	with ju	ustification	
Replaceable Disposable Particulate Powered Air-Purifying Respirators Self-Contained Breathing Apparatu Recommended time period for next questionnaire: Date Completed: Any recommended limitations for respirator use on Medically unable to use a respirator. Informed workforce member of the results of the	e Respirator	_ with ju	ustification	Date
2. Replaceable Disposable Particulate 3. Powered Air-Purifying Respirators 4. Self-Contained Breathing Apparatu Recommended time period for next questionnaire: Date Completed: Any recommended limitations for respirator use on Medically unable to use a respirator. Informed workforce member of the results of the Comments:	e Respirator	with ju	ustification	



ATD RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE Page 4 of 4

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	HSN NO.

DHS-EHS OFFICE STAFF ONLY			
Completion of this form:	Reviewed By (Print)	Signature	Date

GENERAL INFORMATION				
	GEN	JERΔI	INFOR	MATION

THIS QUESTIONNAIRE IS TO BE REVIEWED BY A PHYSICIAN OR LICENSED HEALTH CARE PROFESSIONAL.

8 CCR §5199

Medical evaluation: DHS-EHS or non-DHS/non-County workforce member (WFM) School/Employer shall provide a medical evaluation, in accordance with 8 CCR §5144(e) of these orders, to determine the workforce member's (WFM) ability to use the respirator before the WFM is fit tested or required to use the respirator. For WFM who use respirators solely for compliance with subsections (g)(3)(A) and subsections (g)(3)(B), this alternate questionnaire may be used.

8 CCR §5144(e)

- 1. General. DHS-EHS or non-DHS/non-county WFM School/Employer shall provide a medical evaluation to determine the WFM's ability to use a respirator, before the WFM is fit tested or required to use the respirator in the workplace. DHS-EHS may discontinue a WFM's medical evaluations when the WFM is no longer required to use a respirator.
- Medical evaluation procedures.
 - a. DHS-EHS or non-DHS/non-County WFM School/Employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.
 - b. The medical evaluation shall obtain the information requested by this questionnaire in Sections 1 and 2, Part A.
- 3. Follow-up medical examination.
 - a. DHS-EHS or non-DHS/non-County WFM School/Employer shall ensure that a follow-up medical examination is provided for a WFM who gives a **positive response to any question among questions 1 through 8 in Section 2, Part A** of this questionnaire or whose initial medical examination demonstrates the need for a follow-up medical examination.
 - b. The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

If WFM is unable to be fit-tested or has failed the fit test, WFM must be provided with a powered air-purifying respirator (PAPR).

This form and its attachment(s), if any, such as health records shall be maintained and filed at non/DHS/non-County WFM School/Employer. The School/Employer shall verify completeness of DHS-EHS form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-Employee Health Services (EHS), the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

Health records will be maintained by DHS-EHS or non-DHS/non-County WFM School/Employer and kept for thirty (30) years after the workforce member's employment/assignment ends, in accordance with State and Federal medical records standards and DHS policies and procedures.

DHS-EHS will obtain the workforce member's written authorization before using or disclosing medical information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

A copy of the respiratory protection regulation Title 8 CCR §5144 and §5199 can be found at http://www.dir.ca.gov/title8/5144.html and http://www.dir.ca.gov/Title8/5199.html